COMMUNITY HEALTH WORK 1987

TAI-O CHILDREN PROJECT 1987

Group 5.6

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CONTENT

1. ABSTRACT

The present project was part of the 1987 Tai-O Dental Health Project which had two target groups namely the children and the elderly. The purpose of our project was to introduce a primary health care model of dental service to 6-12 year-old children. Tai-O is one of the most remote communities in Hong Kong.

An organising committee was formed consisting of representatives from eight organizations. Task forces took up responsibilities such as transportation, accommodation, promotion, etc., while members of the Faculty of Dentistry and students were responsible for the planning and implementation of the technical and clinical components of the project.

The 6-12 year-old children were our target group. Treatment service was limited to Primary 5 and 6 pupils. A total of 225 schoolchildren were clinically examined and treated. Baseline data on oral health-related knowledge and behaviour, and clinical data of oral health were collected by means of questionnaires and a pilot survey examination. Health Education programme was held which included school visits (drama and slide-show), a teachers' seminar, singing and slogan competitions, a quiz, exhibitions and demonstrations. A teachers' manual on oral health education was produced. During the five-day treatment phase both preventive and restorative treatment were delivered.

Two evaluation questionnaires were issued, one immediately after the treatment period and another 3 months later, to assess any change in the oral health related knowledge, attitude and behaviour of the children.

The concept of multi-disciplinary team approach was applied in this project. The two student groups co-operated with members of the organizing committee, staff of the Faculty, the ancillary dental personnel of Prince Philip Dental Hospital and the MacLehose Dental Centre. The student group working for the elderly in Tai-O (Group 5.3) was working concomittanly and we co-operated throughout the period.

Some improvement in the oral health-related habits was found, but it was short-term in some aspects. An increase in the oral health knowledge was also achieved but misconceptions still existed after the Health Education programme.

The establishment of an organizing committee will be essential in future projects. The Government should take an active role in providing more easily accessible dental services to the children in Tai-O. Follow-up projects should be carried out to evaluate the long term effect of this project and to modify the approach as necessary.

2. INTRODUCTION - THE TAI-O VILLAGE

2.1 Geographical and social aspects

Tai-O is an old fishing village located at the Western coast of the Lantau Island (see map in Appendix 1). It has a population of about 12,000 and nearly half of them are either under 15 or over 60 years of age. Most of the adults work in the metropolitan area of Hong Kong leaving children to be cared for by their grandparents. Half of the population lives in squatter areas and the living conditions are generally poor. It is noteworthy that the majority of the Tai-O people are satisfied with their situation. There are kindergartens, primary schools and a secondary school serving the children in Tai-O and also children from other areas of the Lantau Island.

Water fluoridation in Tai-O was implemented in 1982. Therefore many older children have not had life-long exposure to fluoridated water either because of their age or the use of well water by their families. More information about the Tai-O community is available in the previous reports of the Community Health Projects conducted by dental students in 1985 and 1986 (1,2).

2.2 Oral health care situation

The dental service in Tai-O is greatly inadequate because the Tai-O population is served by one Government dental clinic which only provides emergency treatment (mainly extraction) one session per month. There is no private dental practitioner in Tai-O. Although the school children from Primary 1 to Primary 5 are eligible for the School Dental Services provided by the Government in **the MacLehose Centre on Hong Kong Island** no transportation service has been arranged for the Primary 4 to Primary 5 students. As a result of this students are very reluctant in spending almost a whole day for travelling to and from the MacLehose Centre which is located in Wanchai. The dental awareness of the Tai-O people is generally poor because of lack of knowledge and misconceptions about dental health and dental diseases.

2.3 Past dental survey in Tai-O

From data gathered through dental surveys in Hong Kong and Tai-O in 1980 (3, 6), the dental caries experience and prevalence of the Tai-O children were found to be higher than for the urban Hong Kong children (Table 1).

Table 1: Dental Caries experience of 6 and 11 year-old children residing in Tai-O and Hong Kong in 1980 (3).

Age	Tai-O	Hong Kong
6	dmft 10.8	dmft 4.3
11	DT 2.5	DT 1.5

In **the 1980 Survey** (3) school children from two primary schools and one secondary school were asked to attend an oral health education programme in the Wing Chor Primary School and in the Community Hall. A total of 434 school children was screened for dental caries, tooth loss and gum diseases by dentists from the University of Hong Kong and volunteers from the Government Medical and Health Service.

Since Tai-O is remote from urban area and transportation services are limited, dental service initiatives are essential. In 1985, a **Survey of the Oral Health Status of the Elderly living in Tai-O** was conducted by a group of dental students (1). The questionnaire inquiry which was part of this survey revealed that the level of dental awareness among the elderly people living in Tai-O was low. It was found that the dental treatment needs were substantial. The demand for dental care, however, was low. In **1986 a follow-up project** (4) was conducted by dental students with the purpose of planning, implementing and evaluating a dental health care programme including simple treatment for the elderly living in Tai-O. Preliminary visits were paid to different sites in Tai-O for screening of patients, treatment planning, the provision of emergency care and the delivery of oral health education.

Based on the success of the 1986 project for the elderly we decided to include the children in our follow-up project in 1987. An **organizing committee** (4) was formed composed of representatives from Government departments, various Tai-O community organisations and the Faculty of Dentistry, University of Hong Kong.

3. AIMS & OBJECTIVES OF THE 1987 TAI-O CHILDREN PROJECT

The **Aim** was to improve the oral health status of the 6-12 year-old children.

The **Objectives** were:

1. **to** introduce a primary health care approach in Tai-O.

2. **to** assess the dental caries status and the dental caries treatment needs.

3. to provide simple dental treatment

4. to evaluate the effect of the project on the oral health related knowledge, attitudes, and behaviour of the 6-12 years-old children in Tai-O.

4. MATERIAL AND METHODS

4.1 Project planning

In December 1986 the first meeting of the **"Tai-O Children Project - 1987"** was held in Tai-O.

At the same meeting an **Organising Committee** (4) was formed which was composed of the following organisations:

1. Faculty of Dentistry, University of Hong Kong;
2. YWCA, Tai-O Community Development Office;
3. Rural Committee, Tai-O;
4. Youth and Community Office (Islands), Social Welfare Department;
5. Islands District Office, City and New Territories Administration;
6. Tai-O Fisherman Association
7. Wing Chor School, Tai-O;
8. Tai-O Alliance Church.

The aims and objectives of the project were formulated. The structure of the Organising Committee and an initial plan were developed. The work load was then divided among the organisations and our students. We were made responsible for the promotion of dental health and dental guidance and advice. The provision of appropriate treatment was also our responsibility.

The Tai-O Dental Health Project was an extensive programme and therefore in need of a variety of resources and a strong financial support. Fortunately from the beginning of our project several organisations and departments supported the project:

Transportation: The M/S "Sir Clementi" Government launch and Government lorries were put at our disposal by the **Islands District Office** for the transportation of equipment, students and staff from Central in Hong Kong to Silvermine Bay in Lantau Island then onwards to Tai-O.

Equipment: The equipment and materials used in the project were sponsored by the **Rotary Club of Hong Kong Northwest**. All other instruments and dental consumables were supplied by various departments of the Prince Philip Dental Hospital. Sponsorship for the toothbrushes and toothpaste was sought and given by the representative of international manufacturers.

Site: The former Fire Station in Tai-O and the Tai-O Community Hall were arranged by the **Tai-O Rural Committee** for the storage of equipment and also for the delivery of dental treatment to the children.

Accommodation: Arranged by the Tai-O citizen interested in the project.

Meals were partially sponsored by **Mr. Kan Yu Kin** the owner of a Chinese restaurant in Tai-O. .

Manpower: People from all organisations contributed a lot during the implementation of the project.

Publicity: **The Social Welfare Department** was responsible for the production of posters and pamphlets. The **Y.M.C.A.** was responsible for making banners. The information officer of the District Office maintained a good relationship with the press and promoted the project by press releases.

The dental students concentrated on the planning of the dental programmes.

The dental care programme was divided into four stages and all 6-12 year-old primary school students were our target group.

Table 2: Absolute numbers of 6-12 year-old schoolchildren in Tai-O schools

Grade	1	2	3	4	5	6	
Wing Chor	45	44	46	47	44	49	(275)
Tai-O Government	26	25	27	27	26	29	(160)
Tai-O	42	40	43	44	40	45	(254)
Total	113	109	116	118	110	123	(689)

Table 3: Age distribution of the 6-12 year-old school children. Percentages .

Age	Percentage
6	13
7	17
8	15
9	16
10	9
11	14
12	13
Total	100 (689)

4.2 Baseline data collection

Data related to demographic information, oral health related knowledge, attitudes and behaviour as well as the oral health status were collected by means of questionnaires and systematic oral clinical examinations. The data served as guidelines for designing the Dental Health Education programme in the second stage and the Treatment phase in the third stage, and as baseline for the Evaluation.

4.3 Dental health education programme

This programme consisted of a teachers' health education orientation, an oral health education drama, slide-shows, health talks, and small group discussions. An exhibition was also arranged aiming at imparting up-to-date information on dental care emphasizing on the prevention of dental caries and periodontal disease to the school children, their parents and their teachers. The misconceptions and misunderstandings revealed concerning oral health care were sought to be clarified.

4.4 Treatment programme

Appropriate simple treatment were delivered to the children using portable dental equipment at the Tai-O Community Hall under close supervision by clinical staff of the Prince Philip Dental Hospital. Complicated and difficult cases were referred to the Government clinic or other dental facilities.

4.5 Working schedule for the Tai-O Dental Health Project 1987

Date	Function
January, 1987	Initial planning Applications for funding Final plan
February, 1987	First round publicity - poster - pamphlet - banner - book marker - press release
March 1987	Second round publicity Education programmes - singing contest - colouring-in contest - quiz Calibration in CDO reception clinic
16 March 1987	Pilot dental survey
17 -19 March 1987	Questionnaire (Q1)
20 March 1987	Teachers' health education Oral health education - slide show - drama - OHI demonstration
10 April 1987	Transportation of equipment
11 April 1987	Variety show Exhibition
14-18 April 1987	Treatment phase
21-24 April 1987	Questionnaire (Q2)
April - May 1987	Evaluation
July 1987	Questionnaire (Q3)

4.6 Evaluation

The dental knowledge of the participants were re-assessed by a questionnaire inquiry. This served as an indicator of the efficacy and adequacy of the Dental Health Education programme with respect to the change in knowledge and oral hygiene habit.

An overall evaluation was conducted by the Organising Committee and published in a separate report (4). We decided to prepare a

report including all information as reference for future community projects.

4.7 The pilot survey

4.7.1 The Aim of the survey was:

to provide the data necessary for the planning of the treatment programme considering the material and human resources as well as the time available.

4.7.2 The objectives of the survey were

a. **to** study the dental caries and the oral hygiene status of the target group

b. **to** determine the content of the treatment programme

c. **to** determine the priorities for treatment

4.7.3 Sampling method

Stratified cluster sampling technique was used. The subgroups were likely to have different disease levels. A standard number of subjects in any one location were examined and specific index ages were used.

The Wing Chor Primary School was chosen as the site for the Pilot Dental Survey. The three primary schools in Tai-O draw school children from families with almost identical social, economic and cultural background. The age groups selected were the 6, 8, 10, and 12 year-old school children.

4.7.4 Sampling size

The total number of primary school students under 12 in Tai-O was around 700. Twenty per cent (about 140 students) was screened. The examination took place in the school hall. The selected students were examined class by class.

4.7.5 Calibration of examiners

It was essential that the six examiners were trained to make consistent clinical judgement. Criteria for the dental examination - recommended by W.H.O. - were clearly and precisely defined (5).

The calibration exercise was divided into three phases. The first phase involved the screening examination of four child patients under 12 attending the CDO reception clinic of Prince Philip Dental Hospital.

They were examined by the six examiners and the results were discussed among the examiners and Dr. Edward Lo who was the supervisor. The second phase of the calibration was conducted immediately prior to the dental examinations in the Wing Chor Primary School, Tai-O. Four children were examined by each examiner and duplicate examinations were conducted. During the survey, one out of each ten children was re-examined by the same examiner to check reproducibility. Students having '5' as the last digit in their examination number were chosen for a single-blind duplicate examination.

4.7.6 Clinical examination

As the survey was conducted to determine the dental caries prevalence and establish a baseline for the planning of the treatment phase a relatively crude level of clinical diagnosis was applied. The rather crude level ensured a high degree of reliability and reproducibility. No radiographs were taken.

Four examination units were set up and manned by four examiners and four DSAs as recorders/scribes. Every subject was examined in a supine position. Fibre-optic light sources with the light reflected onto a disposable plane-surface mirror were used for the examinations. Sickle-shaped caries probes were used. A half-mouth registration method was employed. One upper and one lower quadrant were selected randomly. Care was given to standardize the examination procedures for every subject. Supervising staff members were present and available for consultation and advice. Data was recorded on a specially designed survey form (Appendix 2).

The floor plan for the clinical examination centre is illustrated in Appendix 3. The clinical examination followed the criteria set by WHO (1977). All subjects were informed of diagnosed caries lesions after the examination.

4.7.7 Supporting Activities

The Teachers' Health Education Programme (YWCA Tai-O 16.3.87)

The aim was to increase the level of oral health knowledge of the teachers and to motivate them to act as health educators in Tai-O and to promote oral hygiene.

We had discussions with the teachers as follow-up of our illustrative **slide show.** The etiology and prevention of dental caries and periodontal disease were explained and discussed. Teachers were encouraged to suggest common dental problems among the children in Tai-O, and then we explained what could be done to help the children solving their problems. The necessity of oral hygiene instruction in the classroom for primary school children was also discussed.

An oral health manual in Chinese and English was compiled. The content included the etiology of dental caries and periodontal

disease, the prevention and the role of teachers as health educators. Two copies of the manual were distributed to each school in Tai-O.

4.7.8 The variety show

A variety show was held in the (Fat Ho Secondary School 11.4.87) together with an exhibition in the covered playground. The exhibition consisted of two sections. At one end, boards were set up to introduce general dental health knowledge and to post entries of slogan and posters made by the children in the colouring competition. A complete mobile dental clinic with instruments was also displayed.

The variety show started off with the opening ceremony of the project. The Inter-school singing contest and Quiz (final round) then followed. The audience was entertained by a group of elderly people performing dances. The dental students were also acting as entertainers. Prizes and souvenirs were presented to the children at the end of the variety show.

4.7.9 School visits

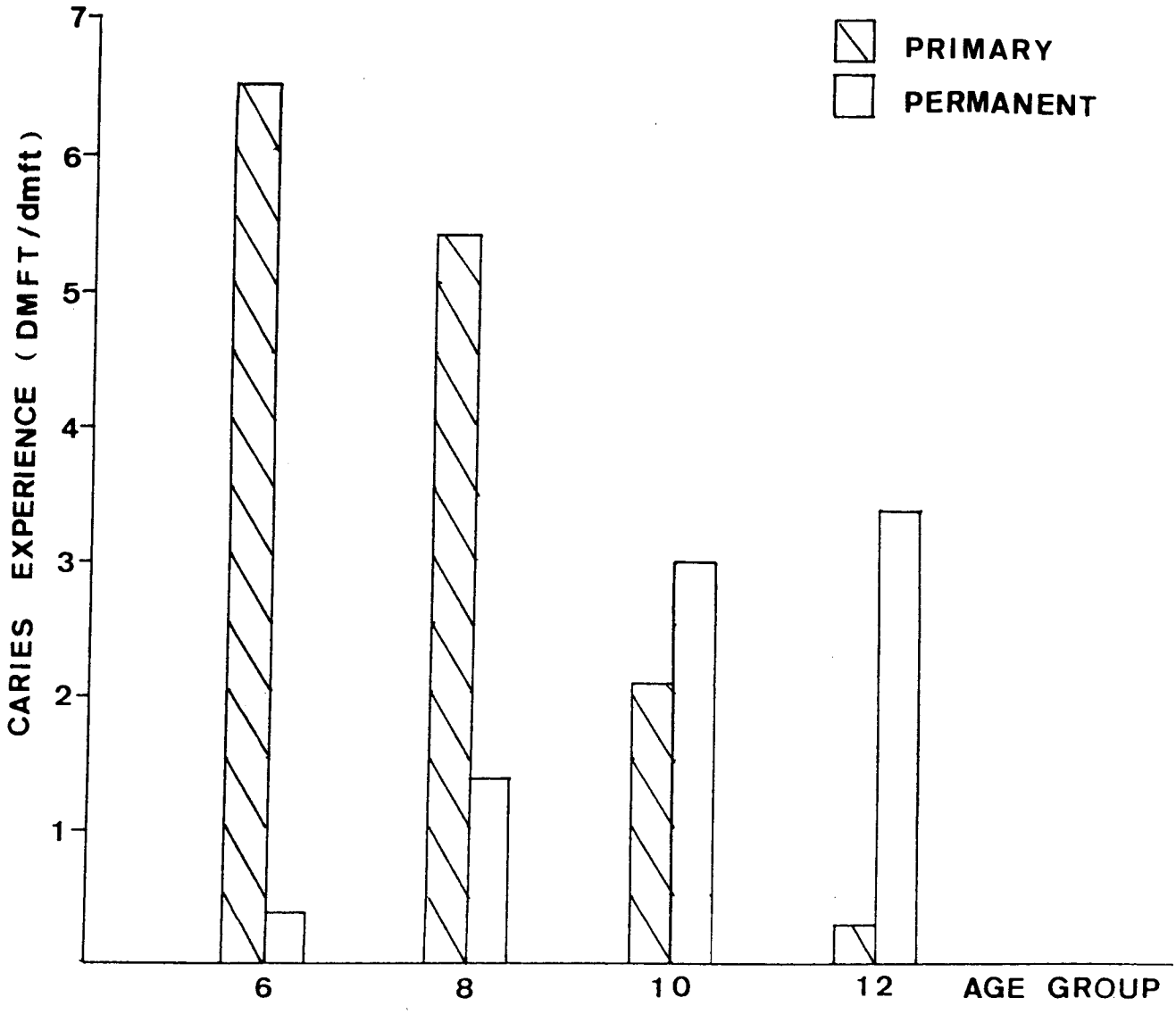
Programmes were arranged in the schools of Tai-O (20.3.87 - 21.3.87) (Three kindergartens, three primary school and one secondary school) to promote dental care. Each visit was composed of the following elements:

4.7.10 Drama and slide show

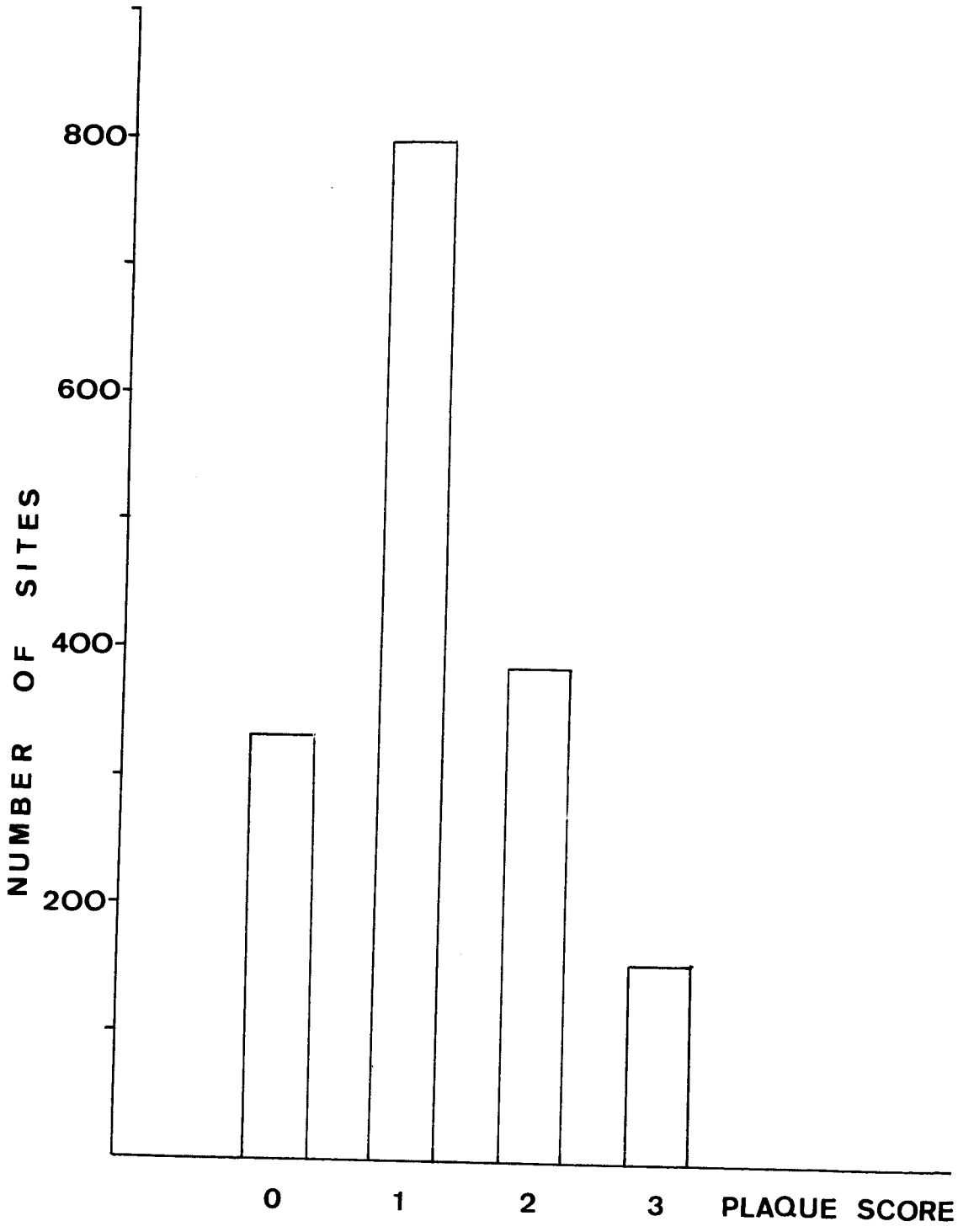
Costumes were designed and made. The drama was rehearsed several times. The whole play lasted for 20 minutes and was designed to arouse interest and attention. The slide show then followed explaining the aetiology of dental caries and periodontal disease. Emphasis was on the preventive measures through diet control, the use of fluoride and an effective plaque control at home. Drama was only given to primary school children. The secondary students were considered to be too grown-up for the drama.

4.7.11 Demonstration

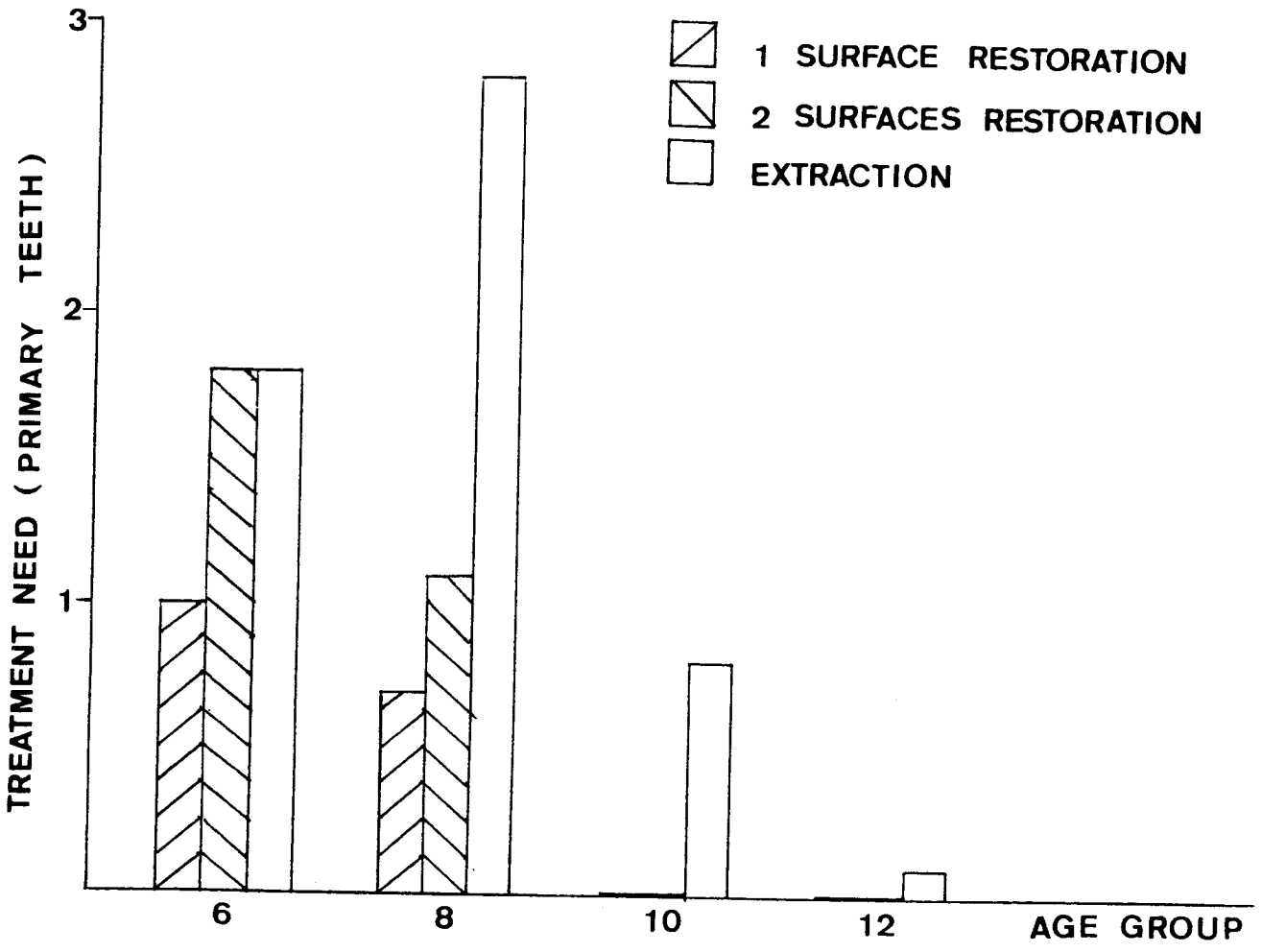
This followed the drama and the slide show. It lasted for about 10 minutes. The children were arranged in groups of ten. In each group, the demonstrator, with the help of plastic models and toothbrushes, reinforced the oral hygiene instruction, gave dietary advice, discussed the selection of toothbrush, and finally a leaflet containing all the information covered was distributed to each child (Appendix 4).



CARIES EXPERIENCE OF DIFFERENT AGE GROUP

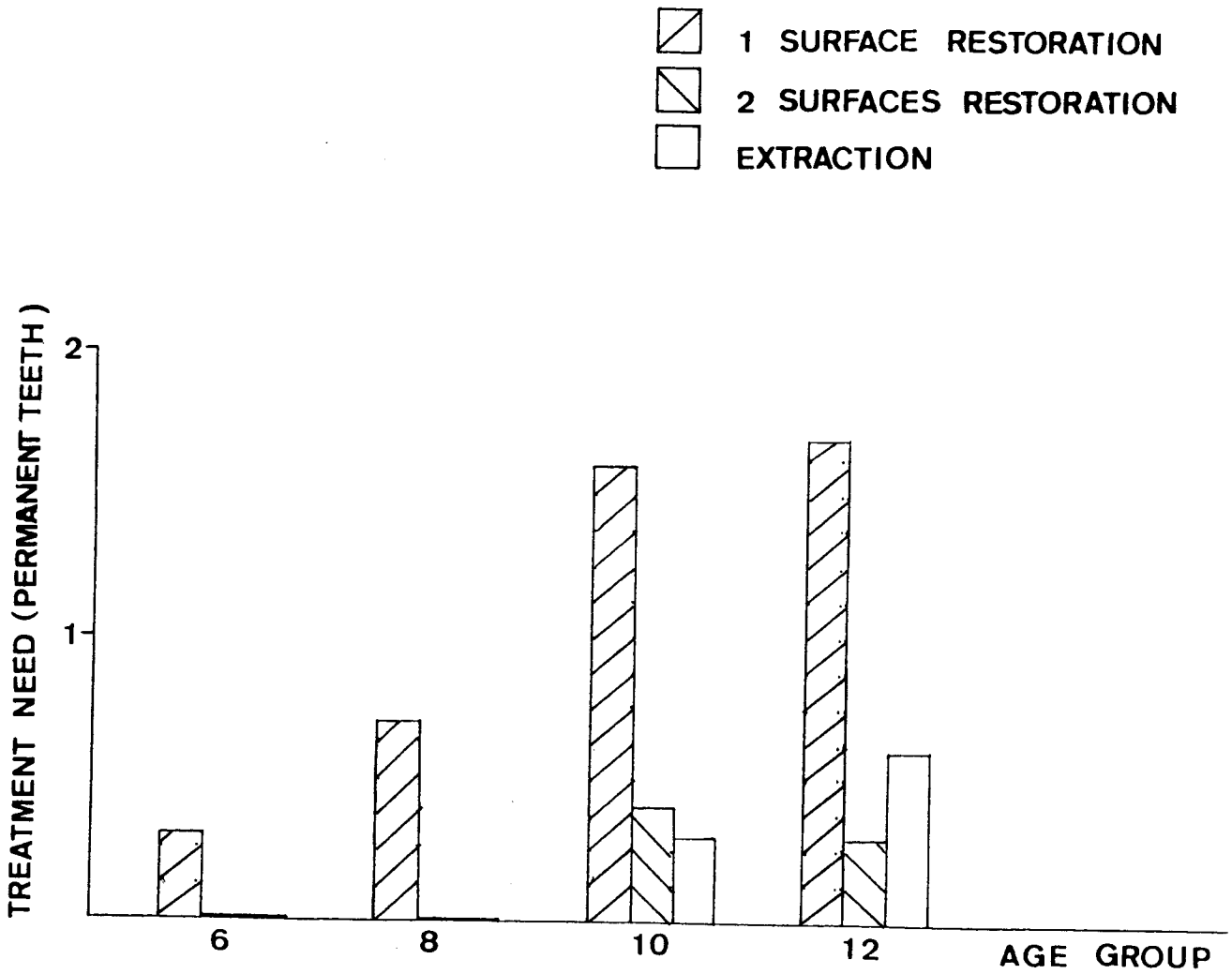


PLAQUE SCORE DISTRIBUTION



TREATMENT NEED OF DIFFERENT AGE GROUP

(PRIMARY TEETH)



TREATMENT NEED OF DIFFERENT AGE GROUP
(PERMANENT TEETH)

4.8 Treatment phase

4.8.1 The objectives were

a. to increase the oral health knowledge

b. to provide simple dental treatment including emergency care and restorations for permanent teeth

c. to introduce a systemic treatment approach for Tai-O children

4.8.2 The treatment priorities were:

* emergency and pain (first priority)

* decayed permanent teeth (second priority)

* decayed first and second primary molars for children under the age of 10. (third priority)

Grade 6 students were found to have more permanent teeth in need of treatment and because children in Grades 1 - 5 were eligible for School Dental Care Service, the Grade 6 students were allocated a higher priority for treatment.

Before commencing the treatment phase an analysis was done to estimate the time needed for the various treatment items. The time estimate was proposed to be 15 minutes for each cavity preparation including the local anaesthesia.

The total estimated time needed for the programme was 31 hours and with three handpieces in operation at the same time, a total of 372 restorations could be made.

4.8.3 Method of treatment delivery

The target group included all Grade 5 and 6 school children in the three primary schools. Their parents were informed by letters before the commencement of the treatment phase. They were required to sign a consent form agreeing to have their children's teeth treated. "Walk-in" patients were treated according to the priority mentioned.

4.8.4 Time schedule

Transportation of equipments to the clinical site was completed on the 10 April, 1987 from 9:00 am to 5:00 pm. Actual **working schedule** for the treatment phase was:

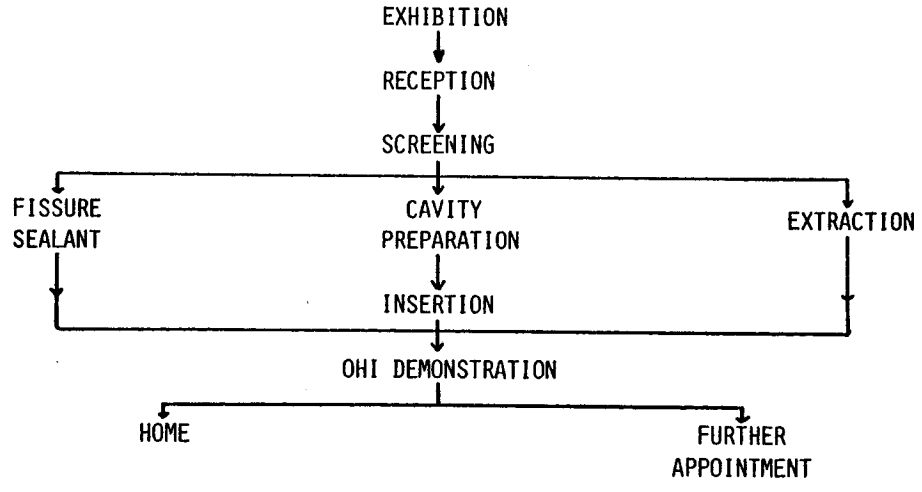
14 April 1987	2:00 pm - 5:00 pm
15-17 April 1987	8:00 am - 5:00 pm
18 April 1987	8:00 am - 12:00 noon

The working format used was a **rotation system** allowing the different operators to become involved in several treatment procedures (see Appendix 5). Services were provided in two different areas. In the **treatment area**, the treatments provided included relief of pain, extraction, clinical preventive measures and restorations of decayed permanent teeth. In the **exhibition area** and at the **demonstration counter** next to the treatment area, services such as dietary advice, oral hygiene instruction and dental health knowledge were given.

On 14-16 April, Grade 5 & 6 students were booked by appointments. "Walk-in" patients were first screened and then eventually treated according to priority when time was available. A maximum number of carious lesions was treated in each visit whenever possible.

On 17-18 April, patients with treatment items that could not be finished on the first visit were given new appointment for completion of their individual treatment plan.

For smooth running of the treatment phase duties of each member of our team were listed on a table (see Appendix 6). **Division of labour** was used with all students working on shift amongst different duties, and work load was equally distributed. Tai-O Community Hall was our work site and the **floor plan** (see Appendix 7) was designed to allow an even flow of patients. Patient flow is shown in the following **'flow chart'**:

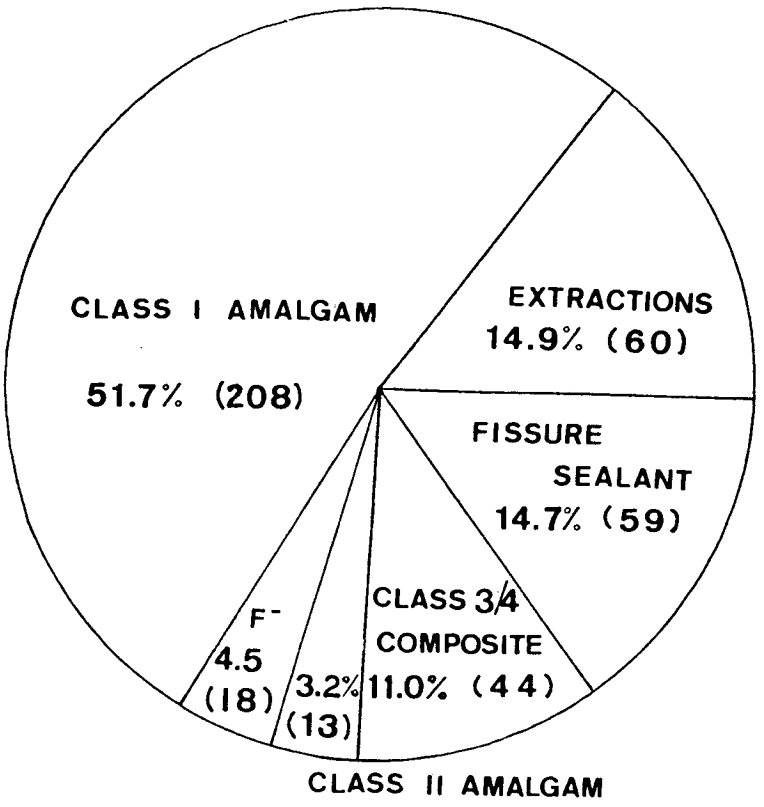


Patient Flow Chart

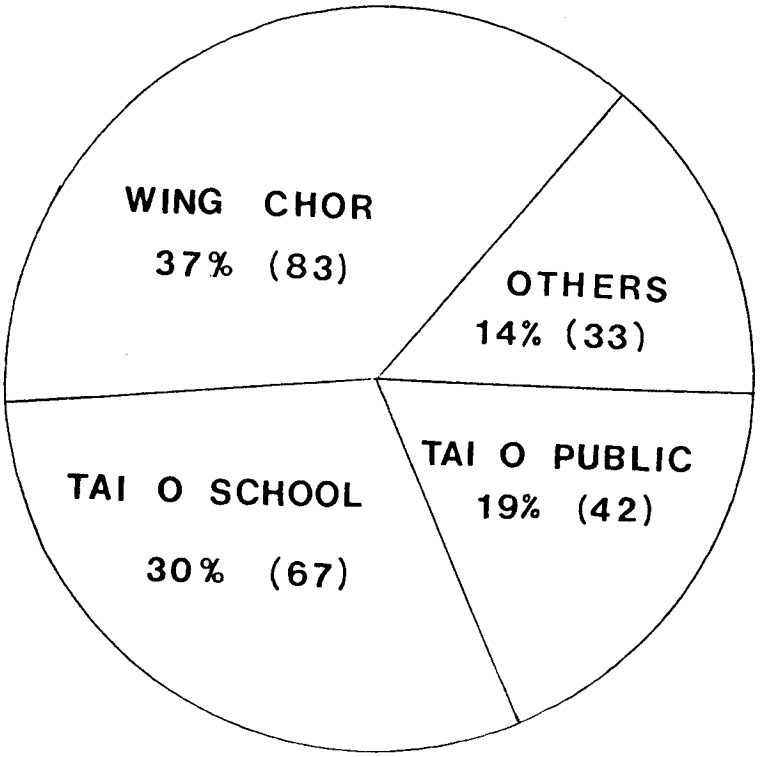
Documents that were used in the treatment phase included **consent form, patient folder, appointment card** (see Appendix 8). Materials and equipment used were listed in Appendix 9.

4.9 Questionnaire inquiry

Our sample included all students (P.1 - P.6) in the Wing Chor Primary School. Questionnaires (Appendix 10) were used to evaluate the programme and they were distributed on three



TREATMENT DELIVERED



SCHOOL PARTICIPATION

occasions,

Q1: 17/3 - 19/3,
Q2: 21/4-24/4
Q3: 6/7 - 10/7

Instructions were given to the school teachers to supervise the students in answering the questionnaires.

The questions were designed to elicit information about oral health related knowledge, attitudes and behaviour from the school children. Findings from the first questionnaire were analysed before the commencement of the project in order to give some ideas for the planning of the dental health education programme. The second and third questionnaires (exactly the same as the first one) were given out to assess the immediate, short-term effect of the programme on the oral health related knowledge, attitudes and behaviour of the sampled children.

5. RESULTS

5.1 Pilot survey

Table 4 Age distribution of the pilot group

Age	**6**	**8**	**10**	**12**
No.	35	41	32	32
Percentages	25	29	23	23

Forty four per cent of the children were females and fifty six were males

Table 5 Dental Caries experience of the pilot group

Age	n	d	m	f	**dmft**	D	M	F	**DMFT**
6	35	6.1	0.1	0.4	6.5	0.3	0.1	0.1	0.4
8	41	5.0	0.2	0.2	5.4	0.7	0.2	0.4	1.4
10	32	1.2	0.2	0.6	2.1	2.3	0.1	0.6	3.0
12	32	0.2	0.0	0.1	0.3	2.6	0.3	0.5	3.4

The dental caries experience of the Tai-O children was much higher than for Hong Kong children of the corresponding age in both the primary and the permanent dentition.

The dmft of the Hong Kong children aged 6 years was 2.7 compared with 6.5 for the Tai-O children. The DMFT for Hong Kong children was 1.4 compared with 3.4 for Tai-O children at 12.

5.2 Treatment needs

Table 6 Dental caries treatment needs of the 6, 8, 10 and 12 year-old Tai-O children

Age	n	Primary dentition			Permanent dentition		
		1 surface	2 surfaces	Extraction	1 surface	2 surface	extraction
6	35	1.0	1.8	1.8	0.3	0.0	0.0
8	41	0.7	1.1	2.8	0.7	0.0	0.0
10	32	0.0	0.0	0.8	1.6	0.4	0.3
12	32	0.0	0.0	0.1	1.7	0.3	0.6

The treatment need in primary dentition was high with respect to extraction which is about 3 primary teeth at age 8. In the permanent dentition the treatment need for restoration was high. A 12 year-old child had two permanent teeth in need of one or two surface restorations. Since the school dental service only covers up to Primary 5 then the children over 10 yr old will not benefit from the scheme. These children were therefore our target group.

Table 7 Dental plaque scores for the pilot group

Age		% sites with plaque score				Mean
	(n)	0	1	2	3	PL I
6	35	21	51	21	6	1.13
8	41	15	46	27	12	1.36
10	32	21	50	20	9	1.17
12	32	24	43	23	10	1.18
Total	140	(20)	(48)	(23)	(9)	1.22

* Numbers in parentheses are average percentages for all four age-groups.

The plaque score of the children was mainly between score 1-2. Only nine per cent of the total sites scored 3.

Table 8 Comparison of dmft and DMFT between Tai-O children and Hong Kong children

Age	dmft		DMFT	
	Tai-O	Hong Kong	Tai-O	Hong Kong
6	6.5	2.7		
8	5.4	2.6		
10			3.0	1.2
12			3.4	1.4

5.3 Results of questionnaires

5.3.1 Personal oral health habits

Table 9 Children's responses to:
Do you have your own toothbrush?

	Q1 (%)	Q2 (%)	Q3 (%)
Yes	96	99	99
No	4	1	1
Total	100 (274)	100 (274)	100 (267)

Responses to the three questionnaires (Q1, Q2 and Q3) showed that nearly all students had their own toothbrush (96, 99 and 99 per cent respectively), and used toothpaste during toothbrushing (97, 97, & 99 per cent respectively).

Table 10 Children's responses to:

How often do you brush your teeth?

	Q1 (%)	Q2 (%)	Q3 (%)
<1/2 days	2	4	4
1/2 days	3	3	5
1 per day	39	25	36
2 per day	45	51	45
>2 per day	11	17	11
Total	100 (274)	100 (274)	100 (267)

Before the health education programme, over 95 per cent of the children claimed to brush their teeth at least once daily. Immediately after the programme, there was a significant increase in the percentage of children who claimed to brush their teeth twice daily (from 45 to 51 per cent) and even more than twice daily (from 11 to 17 per cent). Nevertheless, in the third questionnaire three months after the programme, the percentage dropped back to 45 and 11 per cent respectively.

Table 11 Children's responses to:

How many times did you have sweet snacks yesterday, between the normal meals?

No.of between-meal snacks	Q1 (%)	Q2 (%)	Q3 (%)
0	15	20	17
1	28	29	31
2	25	24	23
3	8	12	13
>3	24	15	16
Total	100 (274)	100 (274)	100 (267)

Prior to the programme, the frequency of snack intake appeared to be rather high, with 24 per cent of the children having more than three sweet snacks the previous day. The programme appeared to alter this as there was a decrease in the percentage to 15 per cent, and the effect was maintained in the third questionnaire (ie. 15 per cent). Correspondingly, there were more children who claimed not to have had any snack intake (from 15 to 20 and 17

per cent respectively).

In summary, there appears to have been a significant improvement in the preventive behaviour of the queried children. However, the effect was rather short-termed, especially concerning their toothbrushing frequency.

5.3.2 Oral health related knowledge

Table 12 Children's responses to:

What are the causes of dental caries?

	Q1 (%)	Q2 (%)	Q3 (%)
Too much sugar	79	80	75
Dirty teeth	68	62	59
Tooth worm	49	56	36
'Hot gas'	8	8	13

Before the programme, a high proportion (79 per cent of the children already knew that the sugary content of food could cause caries and 68 per cent also knew that dirty teeth were another cause. From the second and third questionnaires, those who knew of the sugary content of food remained more or less the same at 80 and 75 per cent; however, the knowledge of dirty teeth being the cause decreased slightly to 62 to 59 per cent respectively. Initially, about half of the children said that caries was caused by 'tooth worm', and although there was a decrease, one third of them still maintained this view.

Table 13 Children's responses to:

What are the causes of gum bleeding?

	Q1 (%)	Q2 (%)	Q3 (%)
Too vigorous toothbrushing	74	79	67
Dirty teeth	18	15	19
Normal phenomenon	22	22	22
'Hot gas'	17	13	18

When asked about the causes of gum bleeding, initially 74 per cent believed that this was caused by too vigorous toothbrushing. Eighteen per cent reported that dirty teeth were a cause, and 17 per cent thought that it was a natural phenomenon. It was a disappointment that after the dental health programme, the percentage of children having these three concepts remained more

or less the same. There were less children who held the misconception of 'hot gas' being a cause immediately after the programme (from 17 to 13 per cent), but the figure returned back to 18 per cent in the third questionnaire.

Table 14 Children's responses to:

Have you heard about Fluoride?

	Q1 (%)	Q2 (%)	Q3 (%)
Yes	80	97	96
No	20	3	4
Total	100 (274)	100 (274)	100 (267)

Table 15 Children's responses to:

What do you think the effect of fluoride on teeth is/are?

	Q1 (%)	Q2 (%)	Q3 (%)
Make teeth look cleaner and whiter	47	53	61
Prevent caries	73	85	83

From the first questionnaire, 80 per cent of children had heard about fluoride. This figure had increased significantly to 97 and 96 per cent respectively following the project. Initially, 73 per cent of the children thought that fluoride could prevent caries. This belief among the children increased to 85 and 83 per cent for Q2 and Q3 respectively. However, there was an increase in the number of who after the project believed that fluoride could make teeth look cleaner and whiter (from 47 to 53 per cent and 61 per cent for Q1, Q2 and Q3 respectively.

Table 16 Children's responses to:

Where do your oral health knowledge come from? (more than one answer can be chosen)

	Q1 (%)	Q2 (%)	Q3 (%)
Parents	68	62	58
Teachers	82	80	78
Friends/classmates	20	29	30
Books	54	56	58
T.V.	54	59	62
Dentists	76	73	71
Nobody	11	10	13

Responses from the questionnaires indicated that the children's knowledge on dental health matters mainly came from their teachers (80 per cent), dentists (~73 per cent), and parents (~63 per cent), other sources included television and books.

It is evident that the children's pre-existing knowledge about of dental health matters was rather poor, especially concerning the causes of periodontal disease. Although there was some improvement after the programme misconceptions still existed particularly relative to the causes of caries and periodontal diseases, and the effect of fluoride.

Table 17 Children's responses to:

Will you go to see a dentist?

	Q1 (%)	Q2 (%)	Q3 (%)
Yes	54	56	54
No	25	23	23
Don't Know	21	21	23
Total	100 (274)	100 (274)	100 (267)

If not, the reason(s) is/are:

	Q1 (%)	Q2 (%)	Q3 (%)
The problem will cure itself	76	64	88
Afraid to go	49	50	42
Too expensive	91	83	90
Too far to go	67	69	73
No one look after my problem	87	83	88

Initially, 54 per cent of the children reported that they would go to see a dentist; immediately following the programme, a slight increase of the figure i.e. to 56 per cent was obtained. Nevertheless, it dropped back to 53 per cent for the third questionnaire. When asked about reasons for not going to see a dentist, almost 90 per cent of the children thought that it was too expensive, 85 per cent said that no one looked after their problem, 70 per cent said that it was too far to go, and 45 per cent said that they were afraid to go. The misconception that a dental problem would cure itself was held by 76 per cent, 64 per cent and 88 per cent for the Q1, Q2 and Q3 respectively.

6. DISCUSSION

6.1 Overview

Our project was aiming at achieving the objectives of the Primary Health Care concept. The whole population of the local community was involved in both the planning and implementation of the project viz the Organizing Committee and the various local organisations, such as the YWCA, the schools and the Social Welfare Department (Hong Kong Government). Our treatment programme and related activities were geographically accessible and financially affordable to our target group in Tai-O.

6.2 Pilot Survey

Assuming that there were no inter-school variations, only one primary school was chosen as the sample so that it was simpler for us to organize and administer the survey and also convenient for the school.

The age-groups selected were the 6, 8, 10 and 12 year-old school children. We decided to take only every other age cohort so that the sample size could be increased for the even age cohorts and thereby improve the reliability. Results for the excluded age-groups can be estimated by intrapolation of the survey data collected. We used a stratified cluster sampling method.

The calibration method was modified so that each examiner could

be calibrated with the supervising teacher (Dr. Lo). By doing so the time spent on calibration could be reduced.

During examination, half-mouth registration was used to save time.

As a result of using the above methods and because of the effective cooperation with the DSAs and the school staff, we were able to finish the survey earlier than scheduled.

The results of the pilot survey showed that our data were consistent with previous surveys. From the data we were then able to derive the treatment needs and the treatment priorities.

6.3 Teachers' Dental Health Program

We assumed that providing school teachers with essential dental health information would prolong the effect of our project. It was our aim to motivate them to act as future dental health educators for their pupils. However, the attendance at the meetings was disappointing and most teachers came from the school which was most involved in the project. They showed greatest interest in solving the dental health problems of the school children.

It was also hoped that the Teachers' Manual would serve as a reference for the teachers when seeking information for their own teaching which would lead to create a long term effect by modifying the dental health related behaviour of the school children.

6.4 Activities prior to the treatment phase

The purpose of the pre-treatment activities (the variety show, the quiz etc.) was to impart dental health knowledge, to promote our project and to create a friendly image which would stimulate cooperation during the treatment phase. This lively approach did really facilitate our project and is to be recommended in future projects. During the quiz, we found that it was a good idea that we acted as judges when controversial answers arose.

6.5 Treatment phase

The priority of treatment was set to be: emergency> permanent teeth>deciduous molars in consideration of the importance of the teeth and their "life expectancy".

Although our target group was restricted to the Primary 5 & 6 originally, other age-groups were also served later due to the un-expected low attendance of our target group.

Since most of our work was of restorative nature and the speed with which of we could do cavity preparation was low, we used a "production line" approach with division of labour to maximize the use of handpieces. Division of labour and the shifting of

duty among us enabled us to experience different jobs without jeopardizing maximum efficiency.

The running of the treatment phase was quite smooth on the whole because of the familiar environment to the children and the friendly atmosphere created through both the pre-treatment activities and our careful handling.

Most of our restorations were done without giving local anaesthesia because the children preferred to endure the discomfort rather than having the injection. It seemed that they tolerated the cavity preparation procedure very well.

Preventive treatment such as fissure sealants and topical fluoride were given by student dental hygienists.

Some problems arose during the treatment period. Firstly, the initial patient attendance was low because the schools were on holidays and so there were few teachers accompanying the children to the treatment hall. Besides, the equipment broke down a few times so that our work was slowed down. The materials we brought were rather inadequate. For instance we had no rubber dam and no light cured composite material. The quality of our composite restorations was less than ideal. Another problem was the co-ordination with the DSAs who had to travel a long distance by ferry and bus Hong Kong Island to Tai-O and therefore arrived late in the morning and had to leave rather early in the afternoon. This made the division of labour quite complicated.

7. CONCLUSIONS AND RECOMMENDATIONS

7.1 Conclusion

The project was planned according to the principles of the Primary Health Care concept. Active participation of the community local groups and leaders greatly facilitated the running of the whole programme. Throughout the project, a team approach was applied involving dentists, dental students, hygienists, dental therapists and dental surgery assistants. Besides, we stressed effective utilization of existing resources including the manpower thus attempting to serve the maximum number of people. We delivered the treatment to the children using a 'Production Line' approach to maximize the use of the few available handpieces. Techniques were modified appropriately to make full use of the existing resources. We focused on a preventive rather than a curative approach.

From the pilot survey we found that the dmft of the children in Tai-O was high compare with the general population in Hong Kong.

Our questionnaire inquiry indicated that increase in the dental health related knowledge was only of short term value and we therefore suggest that other educational methods should be used to ensure a long term effect of the health education programme.

7.2 Recommendation

During the planning and the implementation of our project, we found that the dental services for the children in Tai-O was grossly inadequate. Similar dental health projects for rural area or other isolated areas in Hong Kong are worthwhile. Besides providing service to the under-served community, it gave us an invaluable chance to plan and implement our own treatment programme with limited resources and facilities. But to deal with the problem in the long run, government should shoulder the responsibility and take an active role.

Follow-up review is recommended to evaluate the effectiveness of our work in Tai-O. The most effective mode of delivering treatment, the procedures, and the appropriate materials that will guarantee success when working under such conditions should be determined.

We found that the increase in the dental health related knowledge was short-term and would have required continuing reinforcement. We would like to suggest that more emphasis be given to educating the community leaders and teachers in future projects.

Here are some advice for future dental health projects:

Supporting activities such as variety show, quiz, competitions etc. are worthwhile to establish a good rapport and co-operation with the local people.

To prevent equipment breakdown it is necessary to check equipment before. Somebody should be able to do minor repair work.

The importance of a good image and human approach including "no pain dentistry" should not be forgotten, especially when dealing with children and younger age groups.

Chairside assistance is important and, if possible, the helpers should stay overnight.

8. ACKNOWLEDGEMENT

Our project has received generous support and encouragement from many people to whom we wish to express our gratitude.

We are indebted to Professor O.P. Lind, Dr. Edward Lo and Mr. Kelvin Mak for their help in every aspect of the project.

We would like to thank Professor S.H.Y. Wei, Dr. D. O'Donnell and Dr. Sammy Sou who are the advisors of the project.

A special acknowledgement is due to Miss M. Crosswaite, Miss P. Dando and Miss S. Yip for arranging the CDSA's, the hygienist students and the dental therapists for us. Special thanks also to Mr. Ng Seung Fan and Mr. Leung Hon Sang, social workers in Tai-O.

We would like to thank the **Rotary Club of Hong Kong Northwest** so very much for being our sponsor of our project. Their donation was, indeed, very encouraging and valuable.

We would further like to express our gratitude and appreciation to the **Department of Periodontology and Public Health** and the **Department of Children's Dentistry and Orthodontics.** Thanks to our senior SCDSAs Miss Jenny Leung and Mr. Wayne Chan for providing us with the instruments used in the project.

Thanks to the restaurateur Mr. Kan Yu Kin for his generous support in the form of many meals for many people.

It is not possible to list everyone who provided ready assistance and useful information but we are indebted to all of them.

9. LITERATURE

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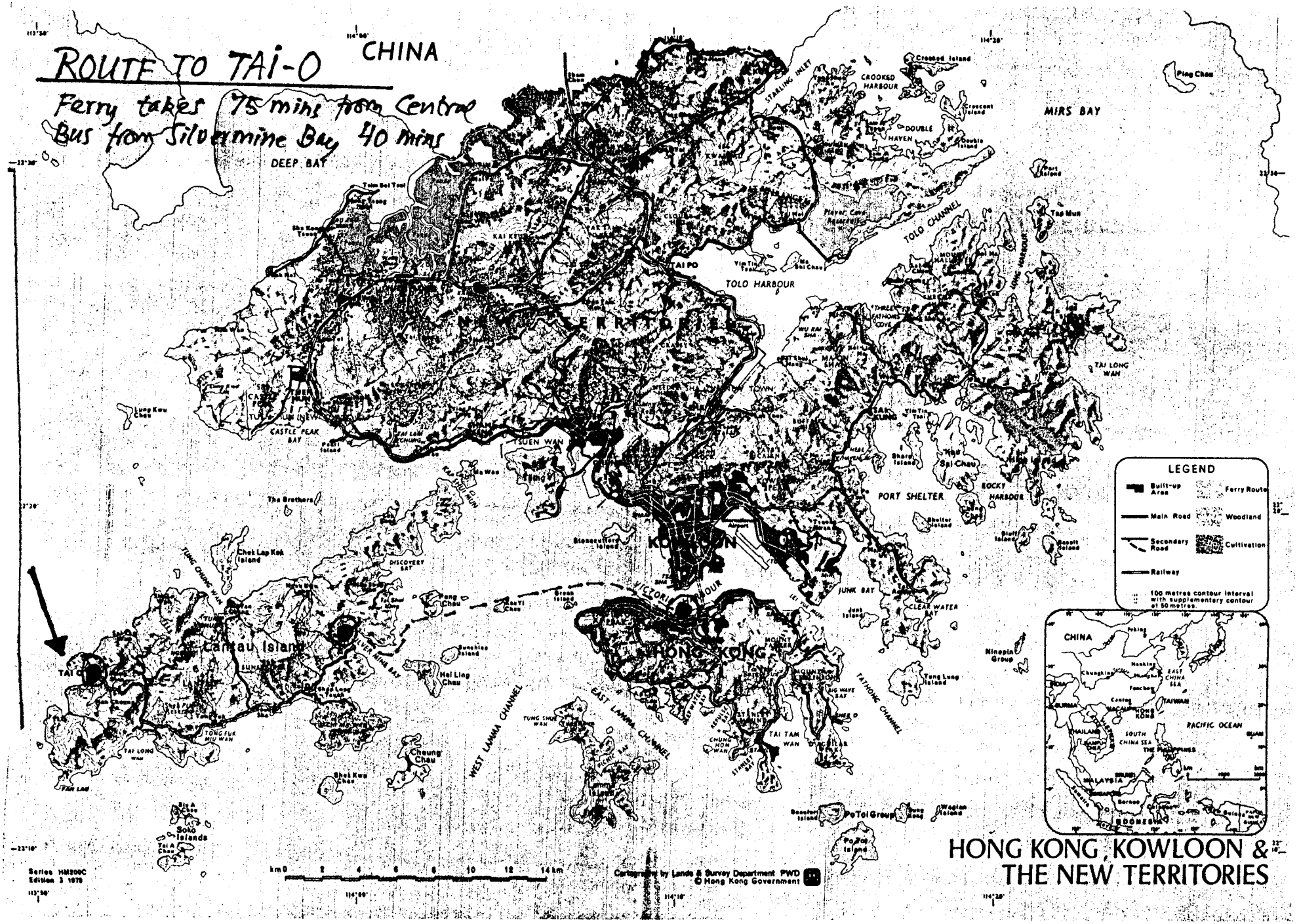


HONG KONG, KOWLOON & THE NEW TERRITORIES

APPENDIX 1

TAI O DENTAL HEALTH PROJECT 1987 (CHILDREN) **APPENDIX 2**

ORAL HEALTH ASSESSMENT FORM

NAME: _____ NUMBER ☐☐☐

CLASS: _____ D.O.B.: ____/____/_____

AGE IN YEARS ☐☐ EXAMINER ☐

SEX (M=1, F=2) ☐ ORIGINAL/DUPLICATE ☐

ORAL HYGIENE STATUS

PLAQUE INDEX

	55	51	65		85	71	75
	16	11	26		46	31	36
B				B			
M				M			

0 = NONE
1 = THIN FILM
2 = VISIBLE
3 = ABUNDANT

STATUS

Permanent Teeth

0 = sound
1 = decayed
2 = filled & decayed
3 = filled, no decay
4 = missing due caries
5 = missing,any other reason
6 = sealant, varnish
7 = bridge abutment or special crown
8 = unerupted tooth
9 = excluded tooth

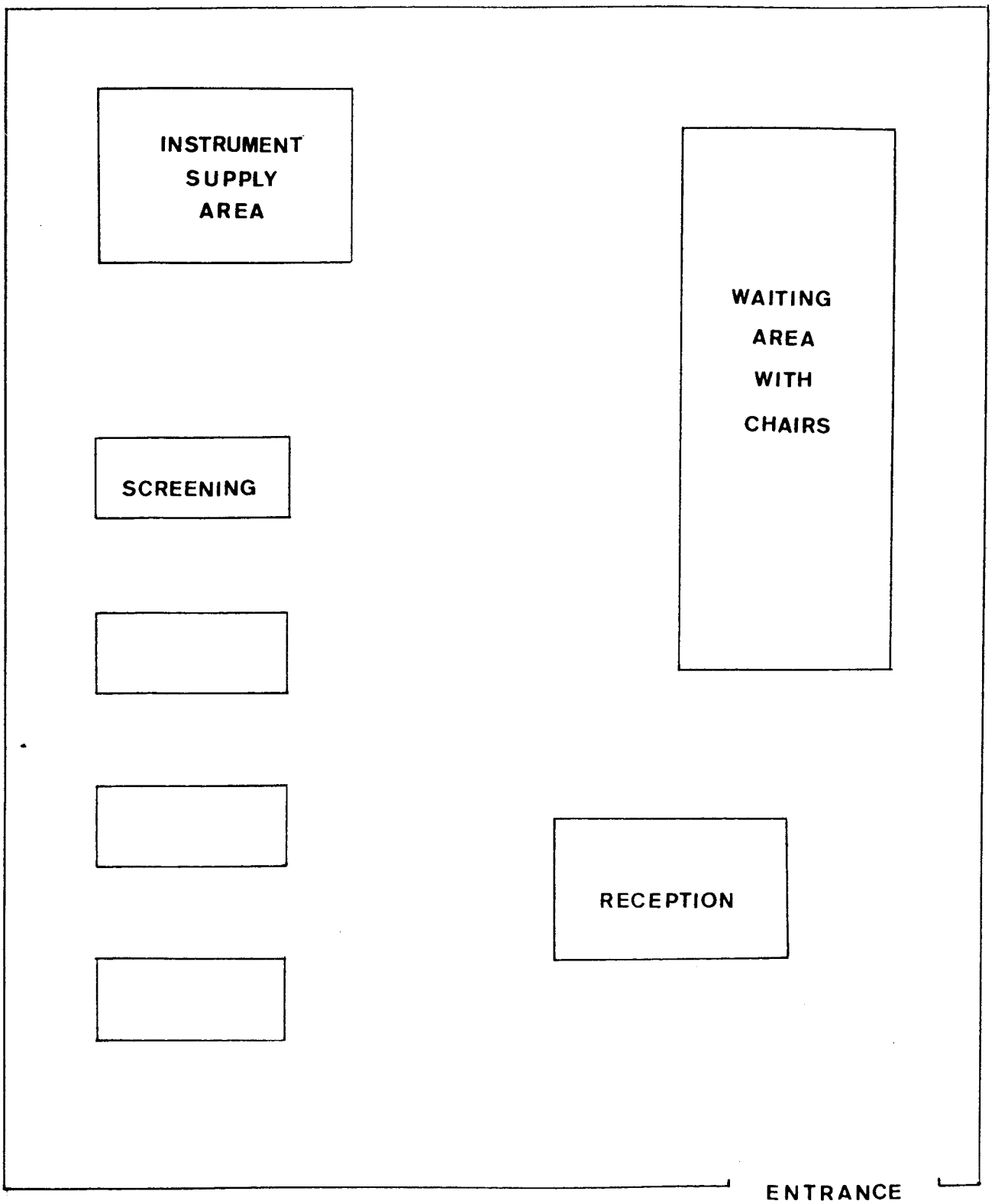
DENTITION STATUS AND TREATMENT NEED

			55	54	53	52	51	61	62	63	64	65				
18	17	16	15	14	13	12	11	21	22	23	24	25	26	27	28
status																
treatment																

			85	84	83	82	81	71	72	73	74	75				
48	47	46	45	44	43	42	41	31	32	33	34	35	36	37	38
status																
treatment																

TREATMENT

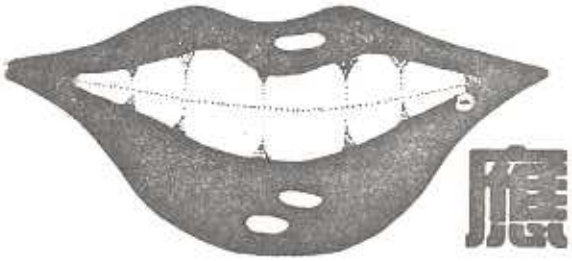
0 = none
1 = caries arresting or sealant care
2 = one surface filling
3 = two or more surface fillings
4 = crown or bridge abutment
5 = bridge element
6 = pulp care
7 = extraction
8 = need for other care
9 = (specify)



FLOOR PLAN OF PILOT SURVEY SITE

WING CHOR PRIMARY SCHOOL HALL

口腔衛生



你應有責

適當的飲食

除早，午，晚三餐外，盡量避免"餐與餐"之間的小食，因為吃小食的次數愈多，蛀牙的機會亦會增加．

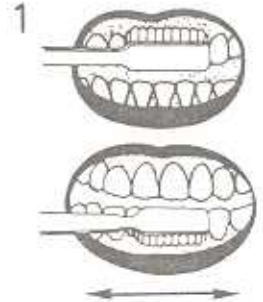
任何甜的飲食如汽水，甜果汁，朱古力，糖等都應該少吃．

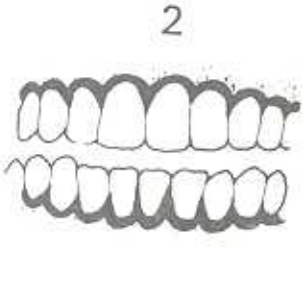
對牙齒無害的食物如牛油麵包牛奶，花生，薯片，芝士，蔬果等都可作為小食．

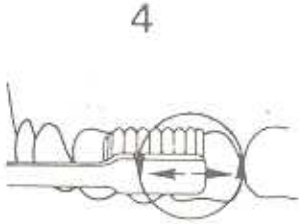
牙膏

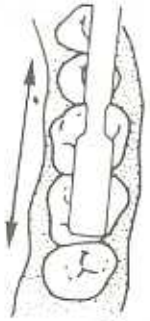
用含有氟素的牙膏，可增強牙齒，預防蛀牙，而少量牙膏已足夠．

刷牙之正確方法









1 刷牙應分開上下刷，有程序的從一邊刷至另一邊。

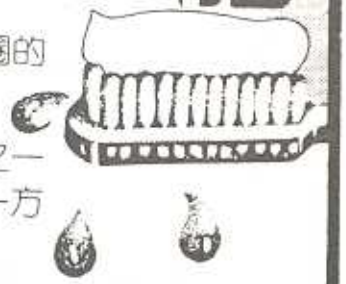
2 牙齒及牙肉的邊緣是最須要注意清潔的地方。

3 在刷牙齒表面近面頰或近舌的一邊時，把牙刷放於牙齒與牙肉邊成四十五度角。

4 刷牙的動作最好是以打圈的方法。

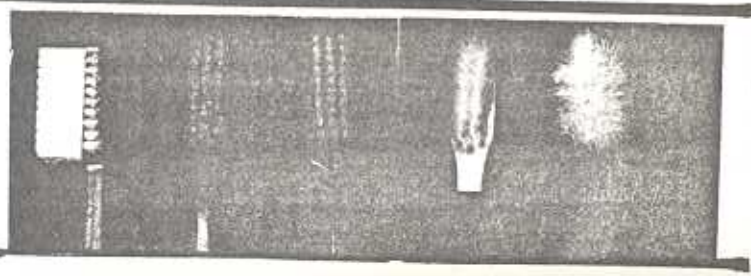
5 不可忘記牙齒向口腔內之一面也要刷。可用上述同一方法。

6 最後是以打橫的方法擦牙齒的平面。



牙刷的選擇

選擇一隻不太大的牙刷，牙刷的毛要中等硬度．牙刷壽命祇是數月，當牙刷毛劈了，就要更換新的．



DIVISION OF LABOUR IN THE TREATMENT PHASE

	14/4	15/4		16/4		17/4		18/4	
	pm	am	pm	am	pm	am	pm	am	pm
CAVITY PREPARATION	MN KN TG	FS PH MK	LS JT WO	FO AB HE	MN MA LU	FS KN AX	LS PH TG	AB JT MK	MA HE WO
INSERTION	AB LS MK	MA AX WO	FO KN TG	MN PH MK	FS JT WO	FO LS HE	MN AB LU	FS MA AX	LS KN TG
INSERTION ASSISTANCE	JT WO	FO HE	MN LU	FS AX	LS TG	AB MK	MA WO	FO KN	MN PH
RECEPTION	FS PH	LS JT	AB HE	MA LU	KN AX	PH TG	JT MK	HE WO	FO LU
SUPPLY ASSISTANCE	FO LS HE	MN AB LU	MA FS AX	LS TG KN	AB PH MK	MA JT WO	FO KN HE	MN PH LU	FS JT AX
EXTRACTION	MA	KN	PH	JT	HE	LU	AX	TG	MK
SCREENING	AX	TG	MK	WO	FO	MN	FS	LS	AB
MANAGER	HA	HA	HA	HA	HA	HA	HA	HA	HA

KEY: AB= ALBERT CHAN, MA= MAY HO, KN= CHRISTOPHER KAN
MK= MAK WING YIU, PH= PHILIP NG, AX= ALEX SO
TG= TANG SHU SUM, WO= WONG YIU KEUNG
FO= FOO TAI CHUEN, HE= HEIDI WONG, MN= MONA LAM
HA= HASTON LIU, LS= LIE SO, LU= LUCAS YUM
JT= JOHN TAN , FS= FRANK SUN

DUTIES AND PERSONNEL THAT INVOLVED IN THE TREATMENT PHASE

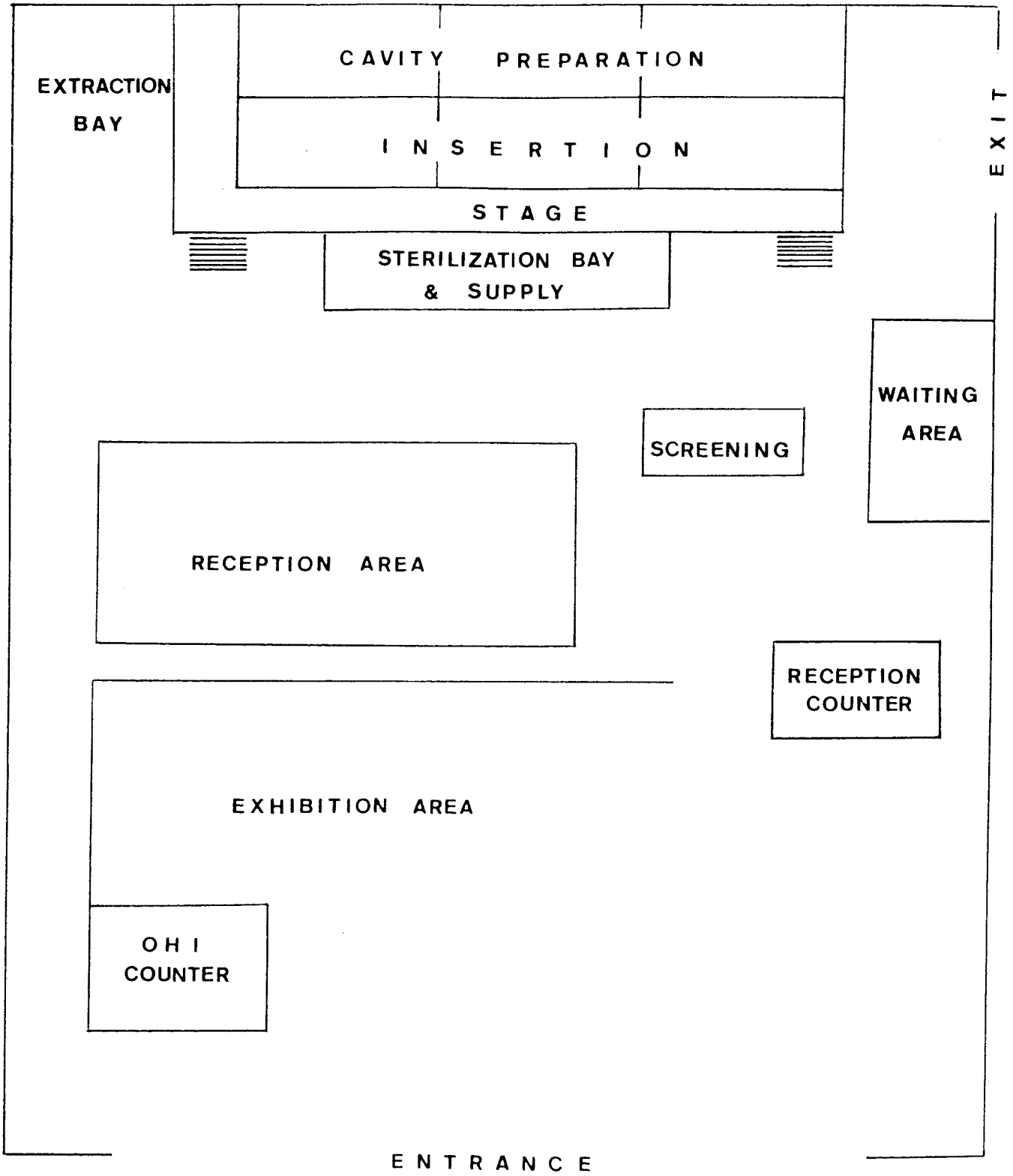
TITLE	DUTIES	STUDENT	STAFF	DSA	HYGIENIST	D.T.
programme manager	programme coordination	1				
receptionist	* history taking * patient flow	2				
screening	screening, T.P.	1	1			
operator for cavity prep.	give L.A. cut cavity	3				
assistant for cavity prep.				3+		
operator for insertion	lining, insertion or even excavate caries	3				
assistant for insertion		2				
extraction	L.A., extraction help insertion	1#				
supply worker	change, sterilze instrument mix material	3				
exhibition	board, OHI demo				3	5*
supervisor	initial, check work		1			
		16	2	3+	3	5*

TOTAL: 24 workers

\# operator for extraction would act as:
(a) an assistant for cavity preparation
(b) an assistant for insertion
when there was no patient for extraction.

* 5 dental therapist came on 15/4/87 to help us for a dental exhibition for all the students of the three primary school in Tai O

\+ DSA were available each day from 10:00 am - 3:30 pm. Before and after this session, 3 students from supply, reception and extraction were shifted to act as assistant for cavity preparation



FLOOR PLAN OF TREATMENT SITE

TAI O COMMUNITY HALL

附錄二

致貴家長／監護人：

茲接獲香港大學牙醫學院通知，該院之教授學生及護理人員將於八七年四月　日在大澳大會堂為本校學生作牙齒健康檢查、補牙及脫牙等治療服務。請於當天帶同貴子女前往接受治療服務。（當天會有牙齒健康展覽及刷牙示範，適合貴家長及子女參觀。）同時請提醒貴子女攜回「天天擦牙表」，表現好的將有紀念品贈予。

現請填妥左方之同意書，交回本校。

校長啟

一九八七年四月七日

致香港大學牙醫學院：

茲同意／不同意本人之子女／監護下之學童

姓名　　級別　　接受貴院之牙齒治療服務。

家長／監護人　　簽署

一九八七年四月　　日

APPENDIX 8 | REG. NO.

TAI-O DENTAL HEALTH PROJECT 1987 - CHILDREN

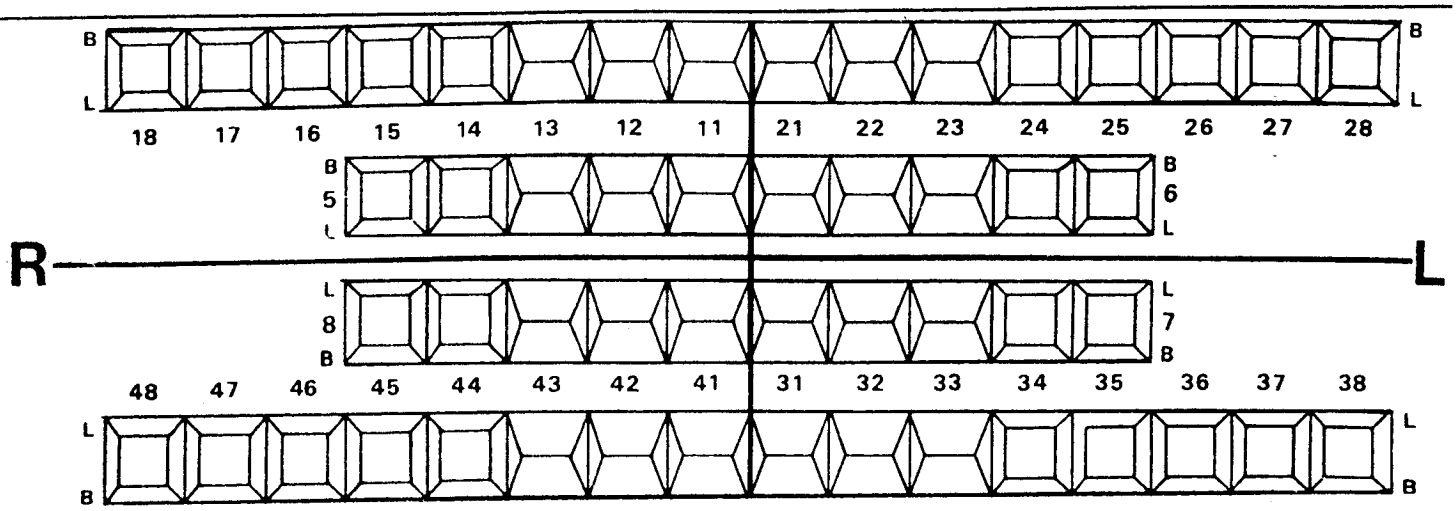
NAME: _____ 姓名: _____

AGE: _____ D.O.B. _____ SEX: _____

SCHOOL: _____ CLASS: _____

ADDRESS: _____

TEL: _____



DATE: _____ _____ _____ SCREEN BY: _____

ate 期	MEDICAL HISTORY 病歷
	Remarks:

This questionnaire is to be completed by the clinician and NOT by the patient		Yes 是	No 否
1. Are you in poor general health? 閣下之健康是否不良？	1		
2. Are you receiving medical treatment from your doctor, hospital or clinic? 閣下是否正在接受醫藥治療？	2		
3. Are you taking any medicine, pills or tablets 閣下現在是否服食任何藥物？	3		
4. Have you attended a hospital previously as an in-patient or out-patient? 閣下曾否入住醫院或在醫院「門診部」接受治療？	4		
5. Have you ever had a general anaesthetic? 閣下曾否接受「全身麻醉」？	5		
6. Are you allergic to penicillin or any other medicine, food or substance? 閣下是否對「盤尼西林」、食物或其他藥物有「敏感」？	6		
7. Do you suffer from hay fever, eczema or asthma? 閣下曾否患「枯草熱」、「濕疹」或「哮喘」？	7		
8. Have you ever had rheumatic fever? 閣下是否曾患「風濕性熱病」？	8		
9. Have you ever had abnormal bleeding after extractions, surgery or injury? 閣下拔牙術、脫牙或受傷時是否流血不止？	9		
10. Have you undergone steroid, anti-coagulant or irradiation therapy? 閣下曾否服用「類固醇」、「抗凝血藥物」或「電療」？	10		
11. Have you ever suffered from jaundice, hepatitis or other liver disease? 閣下是否曾患「黃疸病」、「肝炎」或其他「肝病」？	11		
12. Do you have sudden fainting attacks or giddiness? 閣下曾否突然暈倒或曾覺頭暈？	12		
13. Have you had any childhood diseases? 閣下兒時會否患「水痘」、「麻疹」、「內腮」等症？	13		

TREATMENT PLAN		
RESTORATION	EXTRACTION	OTHERS

APPENDIX 8

ALWAYS BRING YOUR CARD WITH YOU
WHEN YOU COME

Please book an appointment before attending again and produce this card.

If you are unable to keep an appointment please let the Hospital know by telephone and letter and enclose this card.

Letter regarding appointments should be addressed to the Reception Office and not to the Dentist concerned.

Do not attend on any other day without writing in to make another appointment as it may not be possible for you to be seen by the dentist in charge of your case.

Every effort will be made to avoid keeping you waiting but this cannot be guaranteed.

到診時請記得帶備本證

覆診前請先預約，並出示本證。

若未能如約到診，請先用電話通知醫院，然後以書面（請附本證）作實。

預約之信件請寄交醫院接待處收；請勿逕寄負責診治之牙醫。

未經書面預約另定診症日期，請勿自行擇日到診，因負責診治台端之牙醫可能已預約滿額，無法安排爲台端診治。

院方將盡可能不令病人等候，但不能保證病人不需等候。

APPOINTMENT CARD

RECORD NO.

PATIENTS NAME : .....

ADDRESS : .....

.....

Please report to : .....

TAI O CHILDREN PROJECT
PILOT SURVEY

INSTRUMENT AND MATERIAL

disposible mirror	x160	xylocaine & citanest	x20
sickle probes	x40	panadol tablet	4x10 pkt
forceps (deciduous)	x1 set	hibiscrub	x2
elevator	x1 set	consent form	x30
short needle	x10	post-op form	x30
syringe	x3	suture pack (3.0)	x1 box
hand torch	x4	gloves 6.5,7,7.5,8	15@
hand mirror	x4	face masks	x1 box
needle holder	x1	salvon in 70% alcohol	x2 bott.
plaster cheek retractor	x1	sterile cotton wool roll	x10 pkt
suture scissor	x1	sterile cotton gauge	x10 pkt
optic fibre (rd pin)	x4	denture bowl	x20
metal container with lid	x4	cotton wool roll	x1 pkt
first aid box	x1	gauze	x1 pkt
portable dental chair	x4	disposable plastic cup	x50
wash brush	x4	paper towel	x5 roll
autoclave	x1	irrigation syringe &	
lab. gowns	x10	needle	x5
projector	x1	saline	x1
OHI models	x4	alcohol spray 500 ml	x4 bott.

others:

* survey charting form x200
* stationary:
  - (1) HB pencil x48
  - (2) hand board x4
  - (3) eraser x4
  - (4) paper clip x 2 pkt

TAI O DENTAL HEALTH PROJECT - 1987 (CHILDREN)
TREATMENT PHASE

LIST OF EQUIPMENT & INSTRUMENT

dental chair	7
handpiece unit	3
mobile suction unit	6
fibre optic	7
little sister autoclave	1
mouth mirror	10
straight probe	35
sickle scaler	2
push scaler	3
2R/2L, 4R/4L scaler	2@
sharpening stone	1
hand mirror	4
bib chain	7
protective glasses	7
perforated metal box	18
scalpel handle	2
suture kit (needle holder, tissue holder, scissor)	1
metal box	4
excavator: large & small	15@
gingival margin trimmers	5 set
college tweezers	15
condenser	15
carver	15
flat plastic	5
burnisher	18
spatula	4
amalgam carrier	5
surgical suction tube	15
high volume suction tube	12
L.A. syringe	18
plastic flat plastic	5
bur stand	2 metal 1 plastic
tofflemire matrix retainer	3
amalgam titurator	1
amalgam capsule puncher	1
scissor	1
thermometer	1
plastic tray	4

LIST OF MATERIALS AND CONUMABLE

disposable mouth mirror	120
face masks	150
gloves: 6.5	60
7	48
7.5	70
8	10
paper towels	20
sterile gauge	75 packs
claean gauge	800 sheets
cotton wool roll	2000 pieces
cotton buds	1 packet
cotton pellet	half box
salvon	1 bottle x 5L
	10 bottles x 500 ml @
hibisol	5 bottles x 500 ml @
hibiscrub	4 bottles x 500 ml @
alcohol	10 bottles x 500 ml @
saliva ejector	100
plastic cup	400
denture bowl	30
saline	1 bottle
distilled water	2 bottles x 5L @
L.A. short needle	200
long needle	290
L.A. xylocaine	520
citanest	10
dycal	4 sets
cavity varnish	4 bottles
kalzinol	2 sets
mixing pads: small	4 pads
medium	3 pads
amalgam capsule	250
plastic dappen dish	430
amalgam waste bottle	1
burn bin	1
self-cure composite	1 box
IRM	1 box
ledermix	1 box
fissure sealant	1 box
No. 1 matrix band	36 pieces
wooden wedges	1 box
bite-block	230
vaseline	1 bottle
articulating paper	4 booklets
post-op. instruction sheets	134
paracetamol	100 packs x 4 tab @
scalpel blades: #11	10
#15	10
dental floss	2 boxes
cellulose matrix strip	50 pieces
suture (vicryl)	1 box
surgicel	1 box
spray-a-day	1 bottle

rubbish plastic bags:	large	40
	medium	20
autoclave tapes		2
burs: 330		30
246		15
331L		15
straight crosscut #1		15
round bur #1		15
#3		15
#5		15
high speed white stone:	pear	3
	pointed	3
low speed white stone:	pear	3
	pointed	3
irrigation shyringe with blunt needle	(5 ml)	5
	(20 ml)	5
duraphat fluoride varnish		1 bottle
TMS pin		1 box
autoclave bag		50
green sterilizing paper		6 pieces

RECEPTION

desk
chair
patient treatment card
patient consent form
patient appointment card
patient appointment sheet
loud speaker (YWCA)

SCREENING

dental chair	1
chair	2
desk	1
fibre optic (H)	1
bib chain	1
protective glasses (H)	1
hand mirror (H)	1
straight probe (A)	10
disposable mirror (C)	10
alcohol	1
cotton gauge	
cotton rolls	

C : to be collected for cold sterilization in salvon and re-use
A : to be collected for autoclave
H : to be wiped with alcohol

CAVITY PREPARATION

AT BAY:	
dental chair	1
chair	2
handpiece (Siroboys) (H)	1
suction unit	1
fibre optic (H)	1
bib chain	1
protective glasses (H)	1
hibisol	1
cotton gauge	
cotton rolls	
plastic cup *	5
disposable mirror *	5
saliva ejector *	5
bite block *	3
L.A. syringe (A)	3
L.A. needle - long	3
short	2
L.A. xylocaine	5
straight probe *	3
college tweezer *	3
excavator - large *	3
small *	3
bur stand	1
burs (A): 330	
246	
331L	
diamond	
round #1	
#3	
#5	
water container	1
surgical suction tube *	3

ON REQUEST:
scissor (H)
gingival margin trimmer (A)
scalpel (A)
scaler (A)

KEY: H: to be wiped with hibisol
A: instrument to be collected for autoclave
*: instrument to be transferred to insertion if used

LINING AND INSERTION

AT BAY

dental chair	1
chair	2
desk	1
suction unit	1
fibre optic	1
bib chain	1
protective glasses	1
hibisol	1
cotton gauges	
cotton rolls	
plastic cup	5
water container	1
flat plastic	1
condenser	3
amalgam carrier	1
carver	3
burnisher	3
spatula	1
cavity varnish	1
cotton pellet	a few
dycal	1
small mixing pad	1
dappen dish	5
articulating paper	1 booklet

instrument that should come from cavity preparation:
- disposable mirror
- saliva ejector
- straight probe
- college tweezer

instrument that may come from cavityh preparation
- plastic cup
- bite block
- excavator
- surgical suction tube

AT SUPPLY

amalgam titurator
amalgam capsule puncher
amalgam capsule
wooden wedges
matrix band
tofflemire matrix retainer
kalzinol
medium mixing pad
spatula
IRM
composite
fissure sealant
ledermix

EXTRACTION

chair		1
desk		1
L.A. syringe (A)		5
L.A. needle :	long	3
	short	2
L.A. xylocaine		5
forceps :	lower universal 137	2
(A)	upper universal 76	1
	upper premolar fine 765	1
	lower fine root 74N	2
	upper fine root 147	2
	upper right molar 84	2
	upper left molar 95	2
	lower molar 73	2
deciduous	forceps (A)	2 sets of 5 pieces
elevator	LLL	1
(A)	LLM	1
	LLS	1
	CRYER	1 set
	WARWICK JAMES	1 set
sterile cotton gauge		
sterile cotton roll		
surgicel		1 box
post-op instruction sheet		134 sheets
panadol		100 packs
irrigation syringe with blunt needle		
suture kit (A)		1 set
cat-gut suture		1 box
saline		1 bottle

KEY: A to be collected for autoclave

fluoride varnish
cotton bud
cellulose matrix strip
plastic flat plastic
dental floss

KEY: C to be cold sterilized in salvon and re-used
A to be collected for autoclave
H to be wiped with hibisol

香港大學牙醫學院

問卷

你好。港大牙醫學院曾經幾次到大澳為大澳區居民提供牙科服務和健康教育，為了搜集你哋對整個牙齒健康計劃嘅意見，請你在這份問卷適當的空格內[√] 。多謝合作。

第一部份　　牙齒健康教育

1. 你覺得個個牙齒健康話劇好唔好？

☐ 好　　☐ 唔好　　☐ 無意見

2. 你覺得當日嘅小組討論好唔好？

☐ 好　　☐ 唔好　　☐ 無意見

3. 對於整個牙齒健康教育活動，你有哋乜嘢意見，請你寫出嚟。

第二部份　　牙齒檢查及治療

4. 喺今年復活節期間，你有冇去大澳大會堂接受牙齒檢查或治療？

☐ 有（4 → 8）　　☐ 冇（只需答第8,9 題）

5. 如果你有去大會堂，我哋幫你做咗的乜嘢？

(i) 脫牙	☐ 有	☐ 冇
(ii) 補牙	☐ 有	☐ 冇
(iii) 牙紋防蛀劑	☐ 有	☐ 冇
(iv) 教你護理牙齒、刷牙	☐ 有	☐ 冇

6. 如果你有接受上面嘅服務，你覺得果的服務點呢？

(i) 脫牙	☐ 好	☐ 唔好，點解 ----------
(ii) 補牙	☐ 好	☐ 唔好，點解 ----------
(iii) 牙紋防蛀劑	☐ 好	☐ 唔好，點解 ----------
(iv) 教你護理牙齒、刷牙	☐ 好	☐ 唔好，點解 ----------

7. 對於整個牙齒檢查及治療活動有冇其他意見，請寫出來。

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8. 假如下年再有同類型活動你會唔會再參加？

☐ 會　　☐ 唔會

9. 你話你係復活節期間冇來接受檢查或治療，點解呢？

☐ 我唔知有呢個活動

☐ 我冇時間去

☐ 我唔識去

☐ 我覺得冇需要去

☐ 太遠

☐ 我怕見牙醫

☐ 我不在大澳

☐ 其他原因，請寫出來 ----------

< 完 >

-- 多 謝 合 作 --